VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dlp.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 6, 2016

Paula Pelkey, Manager
The Residence At Otter Creek
350 Lodge Road
Middlebury, VT 05753-4498

Dear Ms.. Pelkey:

The Division of Licensing and Protection completed a complaint investigation at your facility on **September 22, 2016**. The purpose of the survey was to determine if your facility was in compliance with Vermont Assisted Living Residence Regulations. The survey statement is enclosed. This survey found the most serious deficiency in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy. You must submit a plan of correction. Please write/type the Plan of Correction in the space provided to the right. A completion date for each plan of correction must be indicated in the far right hand column. Attach additional pages if necessary.

Please sign, date, and indicate your title on the bottom of the first page of the report and return this report to this office no later than **October 19, 2016**.

Plan of Correction (POC)

Your POC must contain the following:

- What action you will take to correct the deficiency;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective actions will be monitored so the deficient practice does not recur.
- The dates corrective action will be completed.

You may also request an informal review of all or part of the contents of the notice at any time prior to **October 19, 2016** by calling Suzanne Leavitt, RN, MS, Assistant Division Director, or Clayton Clark, Division Director at (802) 241-0480. If you are not satisfied with the outcome of the informal review with the Division, you may request a review by the Commissioner of Disabilities, Aging and Independent Living. To request a review with the Commissioner, call (802) 241-2401.

The Department is authorized to impose sanctions for failure to correct a deficiency and/or failure to provide proof of correction by the specified Correction Date. Depending on the nature of the violations, the following sanctions may be imposed: administrative penalties of up to $10.00 per resident or $100.00, whichever is greater, for each day the violation remains uncorrected; suspension, revocation or modification of an existing license; refusal to renew a license; suspension of admission or transfer of residents to an alternative placement; injunctive relief to enjoin any act or omission; and the appointment of a receiver for a facility. If you feel strict compliance with the law or regulations would impose a substantial hardship, you may apply to the Department for a variance as stated under Section III of the Residential Care Home Licensing Regulations. You must do so prior to **October 19, 2016**.

Appeals

As noted above, you may seek an informal review from Suzanne Leavitt, RN, MS, Assistant Division Director, or a Commissioner's review of this decision. In addition, you have a right to request a fair hearing with the Human Services Board. Decisions by the Department of Disabilities, Aging and Independent Living can be appealed to the Human Services Board pursuant to 3 V.S.A. §3091. The request for a fair hearing before the Human Services Board must be made within thirty (30) days of your receipt of the notice of this decision, and can be made by writing to the Board at 14-16 Baldwin Street, Montpelier, VT 05633-2536. You have a right to appear before the Board and to present witnesses and other evidence with regard to the case. You also have a right to be represented by an attorney at the Human Services Board fair hearing.

Please contact me at (802) 241-0480 if you have any questions.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1008	A. BUILDING: _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT OTTER CREEK	350 LODGE ROAD MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint and self report investigation was conducted on 09/19/16 by the Division of Licensing and Protection, and completed on 09/22/16. The following are State Regulatory findings as a result.	R100		
R165 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the nurse failed to ensure a process for communication with staff about the effect of medications for 1 of 4 residents (Resident #3). Findings include:	R165		

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R165	Continued From page 1 Per record review, on 03/09/16 Resident #3 had been administered a PRN medication that was not effective for the resident, but the lack of effectiveness was not communicated to the nurse or prescribing physician. Review of the MAR [administration administration record] shows that on 03/09/16 PRN Ativan 0.25 mg [anti-anxiety] was given and it was noted that it was not effective. There is no indication that the nurse and or physician were notified. Per interview at 3:12 PM with the Reflection Care Director (RCD) acknowledged that the expectation is that staff record the effectiveness and notify the nurse and/or MD if the medication was ineffective. The RCD confirmed lack of notification of the ineffectiveness of the PRN medication and insufficient documentation.	R165		
R207 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced by: Based upon record review and interviews the Residence failed to report allegations of possible financial exploitation, as well as incidents of	R207		

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R207	Continued From page 2 abuse for two of the three residents in the sample, to the State Licensing Agency. (Residents #1 & #2) Findings include: 1. Based on record review and interview, the licensee and/or staff failed to report a suspected incident of financial exploitation (missing money) for 1 applicable resident (Resident #2). Resident #2's assessment dated June 2015 shows the resident's short & long term memory is 'ok' and has no impaired decision making abilities. Per review of the incident report dated 02/21/16, missing money was reported to staff. An internal investigation was conducted but was inconclusive. Per interview in the afternoon of 09/19/16, the Administrator stated "we couldn't determine if money was missing, or if [the resident] tipped [staff] or gave some money to [guest who were visiting]". The Administrator stated that because the internal investigation concluded that the allegation was most likely not valid, did not realize it should be reported to APS. S/he confirmed that, the allegation had not been reported to APS. 2. Resident #1 had a diagnosis of Alzheimer's and was identified and assessed as having socially inappropriate/disruptive behavioral symptoms. During the course of six months (February 2016 through August 2016) only one allegation was reported to the State Licensing Agency. The resident was identified through incident reports as entering other residents rooms uninvited [three times], cornering two residents touching and verbalizing inappropriate comments, charging at a resident and (the reported incident of) hitting/screaming at a resident. Per the reports, Residents stated that they felt "startled", "scared", "frightened", "uneasy" and "made everyone feel uncomfortable". In addition,	R207		

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R207	Continued From page 3 several of these reports show no further investigations or follow up actions. The Administrator acknowledged the above information at this time. Also see R-208	R207		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to ensure that a pattern of resident to resident incidents were reported as required for 1 of 4 residents reviewed (Resident #1). Findings include: 1. Resident #1 had a diagnosis of Alzheimer's and was identified and assessed as having socially inappropriate/disruptive behavioral symptoms. In reviewing incident reports and progress notes, there were a number of incidents involving this resident that were not reported to the State Agency regarding the pattern of aggressive behaviors. The Service plan dated 11/06/14 directs staff for ongoing monitoring and	R208		

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R208	Continued From page 4 re-direction, on-going discussions with [family] about behaviors and plan to meet resident needs, keep safe as well as entire community. On 04/11/16 and 04/14/16 the resident entered, unannounced, a private residence, scaring and startling that person and cornering two residents, touching and verbalizing inappropriate comments, respectively. There is no documentation of a follow up plan at this time. On 05/17/16, after another altercation, the service plan for Resident #1 stated if resident has not been visualized within an hour, radio contact needs to be made to all units and front desk, please locate resident. Twice on 07/13/16 (morning and afternoon) Resident #1 entered Resident #4's room, as reported, "in a panic..(saying) that the scary [Resident #1] was in my room". On 07/18/16 Resident #1 charged at a resident in the lobby, frightening that person. Staff apologized to the frightened resident regarding Resident #1's behaviors. Although the incident report's follow up review denotes ongoing monitoring and on-going discussions with resident's sister about behaviors and plan to meet residents' needs and keeping resident safe as well as entire community, there no specific or further updated interventions to the service plan. The Director of Nursing during interview on 09/21/16 at 1:50 PM acknowledged the lack of reporting for pattern of abuse and lack of documentation of revised plans to deal with the behaviors. Also see R-207	R208		
R213 SS=B	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the	R213		

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R213	Continued From page 5 resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to assure that every resident is treated with consideration, respect and full recognition of the resident's dignity, and privacy. Findings include: 1. Per the incident reports and progress notes, during the course of six months (February 2016 through August 2016) Residents stated that they felt "startled", "scared", "frightened", "uneasy" and "uncomfortable" about the pattern of threats and inappropriate behaviors by Resident #1. Please refer to R-207 & R-208 for examples. The Administrator, during interview on 09/19/16, acknowledged the above information at this time and reported the Resident no longer resides at this facility.	R213		